DOCUMENT RESUME

ED 184 192 CS 502 887

AUTHOR Carek, Donald J.
TITLE Examination Room Conversation: A Physician's Perception.
PUB DATE Apr 80
NOTE 22p.: Paper presented at the Annual Meeting of the Central States Speech Association (Chicago, IL, April 10-12, 1980). Photographs will not reproduce clearly.

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Children: Clinical Diagnosis: *Communication (Thought Transfer): Educational Needs: Medical Education: *Medical Services: Parent Role: *Pediatrics: *Physical Examinations: *Physician Patient Relationship: *Speech Communication

ABSTRACT

Three functions of physician/patient communication are examined in this paper: its functions as a diagnostic tool, as a means of gaining compliance with prescribed medical treatment, and as treatment. The paper first notes the importance of doctor/parent interaction in the case of child patients, describes basic models of the doctor/patient relationship, and considers the roles of the doctor and of the patient. It then discusses the importance of communication as a diagnostic tool, stressing the need for the physician to attend closely to the early minutes of the physician/patient encounter and to take an active role in diagnosis. Next, the paper examines communication as a means of gaining compliance with medical treatment, discussing factors that enhance and impede compliance, general recommendations for the improvement of compliance, and ways doctors can approach the parents of child patients in a way that brings about compliance. In discussing communication as treatment, the paper observes that communication is likely to effect treatment if the physician demonstrates a warm, genuinely empathic approach and if the focus is on the patient: it also enumerates some specific ways in which communication offers treatment. The paper concludes by outlining areas that ought to be highlighted in training physicians for more effective communication. (GT)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED184192

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

Examination Room Conversation: A Physician's Perception

by

Donald J. Carek, M.D.
Professor and Chief, Youth Division
Department of Psychiatry & Behavioral Sciences
Medical University of South Carolina
Charleston, South Carolina 29403

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Donald J. Carek

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

CS502887

Conversation between a physician and a patient is but part of their total communication in a complex interaction that centers around diagnosis and treatment. As this conversation needs to be considered within the broader interaction between the two of them, there are a number of features in this interaction that need to be addressed.

First, there is the matter of the participants in this interaction. When a young child is the patient the doctor-patient relationship takes on a new dimension since the parent also is ordinarily involved. In fact, it is likely that the relationship may center around the interaction between the doctor and the parent. It usually is the parent who provides the necessary information so that the history is reflected through the eyes of the parent. Treatment is also likely to involve an agreement between the two adults concerning what needs to be and what will be done for the child. It comes as no surprise, therefore, that pediatricians are reported to consider rapport with the parents as more important in their treatment of children than rapport with the children.

It appears that in the usual situations of acute illness such concentration on the doctor-parent relationship may suffice. It may even be reasonable to think of the physician as the one on whom the parent can lean for support and counsel so that she/he may be more reasonably supportive of her/his child. Accordingly it may also be best for the physician to support the parent-child relationship and to do all possible to avoid intruding himself between the two of them in a disruptive manner.

The more chronic the condition under consideration or the more it involves behavior problems the greater the necessity also to communicate with the child alone for assessment and supportive help. It is difficult to provide for him adequately in these instances unless there is opportunity to learn more about his feelings and fantasies. Thereby the relationship with the child is bound to come more in focus. It might be kept in mind that child psychiatrists, who engage with children regularly in such a relationship, are reported to see rapport with the child to be more important than rapport with the parent.

Second, there is need to consider the nature of the doctor-patient relationship itself for how the two (or three) participants in this interaction view each other may have much influence on how they communicate with one another.

Szasz and Hollender (14) have described three basic models of the doctor-patient relationship as follows:

1. The model of Activity-Passivity, in which the physician does something to the patient.
2. The model of Guidance-Cooperation. Herein the patient seeks help and is ready and willing to cooperate while he places the physician in the position of power. However, in contrast to the first model, in this one both participants are active though it is expected that the patient will cooperate with the physician who provides the leadership.
3. The Model of Mutual Participation. This model is based more in a spirit of equality. Herein "essentially the physician helps the patient to help himself."

Though these authors note that "in an evolutionary sense, the pattern of mutual participation is more highly developed," (14) it is unrealistic to put premium on any model of interaction without considering the context in which the interaction occurs. By virtue of his training and development of professional discipline, the doctor ought to be the one who can set the tone for the type of interaction and the one who can guide it into a reasonable framework.

It does seem safe to say that mutuality in the relationship is a desirable feature. However, attempts at "mutual participation" ought not rest on a falsely conceived egalitarianism. While the physician and the patient need to have a mutually shared respect for the dignity of the other they also need to realize that the roles to be played by each are bound to be different. Though the physician may not be authoritarian, in this interchange he does hold an authoritative position by virtue of his knowledge and the power vested in him by society. While not expected to be passively submissive, the patient does need to become dependent to the extent that he relies on the physician's diagnostic ability and therapeutic acumen.

Within this broad background the roles of the two can be and need to be delineated even further. The physician's authoritative position is more prominent in the diagnostic and special treatment aspects of the interaction. However, such a position is ever less reasonable when development of the general treatment program includes more than prescription of medication and specialized medical treatment. Herein it is more reasonable for the physician to share with the patient his assessment of the problem and his

delineation of what needs to be done with an invitation to the patient to discuss with him the means by which the task can be carried out. Such discussion allows for a blending of the theoretical world of the professional and his textbook with the real world of the patient so that they may arrive at a practical plan that the patient is able to carry out.

Lastly, there is the matter of physician-patient communication itself. It is a multipurposed process from which the following three functions can be reduced:

1. Communication as a diagnostic tool
2. Communication as a means of gaining compliance
3. Communication as treatment

While it needs to be remembered that these three functions are integrally involved in the total interaction between the physician and the patient, each will be considered separately though the overlapping of functions will become evident in the discussion.

Communication as a Diagnostic Tool

The importance of communication between the physician and the patient as a diagnostic tool is highlighted in oft repeated maxims like "history is 85% of the diagnostic process." They alert the clinician to the fact that communication between him and his patient is relatively more important than the physical examination and other diagnostic procedures.

"Listen to the patient and he or she will make the diagnosis for you" does find support in findings of Korsch and her coworkers. (10)

In their study of 800 pediatric outpatient visits, all but 65 of the mothers specified what they assumed to be the diagnosis before the visit and in a great many instances their diagnosis was the same as or highly similar to the doctor's.

Communication to arrive at diagnosis involves more than verbalized bits of information, or computers indeed might supplant physicians. As the non-verbal accompaniments are likely to weight the verbalizations one way or other, seasoned clinicians are likely to view the early minutes of the physician-patient encounter as especially important. Moser (11) writes, "the first five minutes are the most precious interval in the entire interview ..... I want eyeball-to-eyeball contact. I want to listen to the inflection of voice. I want to evaluate nuances of word, turn of phrase. I want to study body language, facial expression, skin color, sweat, sequence of thought, and the myriad of other messages, subliminal and overt, that pass between human beings."

When it comes to the psychiatric interview - and any clinical encounter has elements of such an interview - Sandifer and coworkers (13) report that "the first three minutes of observation have a significant, and sometimes apparently decisive impact upon the final diagnostic decision." "The issue is probably not so much whether this impact is desirable or undesirable but a clear recognition that it occurs."

These observations bear on the nature of the diagnostic process. That is, it does not appear to involve a passive reception of information followed by an active organization of it in development of a diagnosis. Dobbs and Carek (8) have described it as an active process wherein the examiner quickly arrives at

hypotheses that he confirms or rejects with the aid of additional information. Or what Sandifer and coworkers say of psychiatrists may very well be true of clinicians generally. That is, they "do not seem to function like the adding machine, deferring the final tabulation, until the last entry is made, but rather much more like a sensing or tracking device that seeks and zeros in on its target." (13)

Communication as a Means of Gaining Compliance

Reports in the literature indicate that the extent of noncompliance with medical treatment is significant. Becker (2) notes that in most studies one-third of the patients fail to follow their physician's advice. The number jumps to about 50% when the advice is preventive in nature, when the patients are without symptoms or when the regimen is long-term. In low income populations noncompliance is frequently reported to be more than 60%.

The factors that enhance compliance and those that impede it remain elusive while the search for significant variables goes on. Among the demographic variables Becker (2) notes that noncompliance with medication is associated with the extremes of age, with the very young perhaps resistant to ingesting medicine that may taste bad and the geriatric patients more prone to forgetfulness and self-neglect.

In the study of a pediatric patient population Francis and Korsch (9) reported no statistical correlation of compliance with socioeconomic status, educational level, ethnic background, family size, number of siblings or patient's age. Compliance correlated above all with the mother's degree of satisfaction with the

physician and with the clinic. Reportedly the mother was more likely to express satisfaction when she felt that her expectations had been met, when the physician had elicited and had respected all of her concerns. In addition satisfaction rested on feedback about her child's condition and progress and the physician's expression of warmth and sympathy.

They found that a correlation between satisfaction and compliance was marked at the extremes of the scale with the highly satisfied mother more compliant than those grossly dissatisfied. The relationship still is not a simple one for there were the highly satisfied who did not follow through with the medical program while some grossly dissatisfied did follow through.

Difficult technical language was an outstanding barrier to communication in more than a half of the visits in the study of Korsch and coworkers (10). This language included anatomical or physiological terms and simply hospital "shorthand" words like "workup" or "history." In another survey of 100 patients who attended a medical clinic Collins (6) discovered that on an average the patients understood only 11.9 of the 20 commonly used technical words in a nursing or medical interview. Only 62 understood one-half or more of the words and none understand all of them.

There is one other notable comment about the verbal content. Korsch et al. (10) emphasize that a physician needs to pay attention to the parent's ideas about the illness and the family's expectations from the medical visit. From their findings they conclude that the following two questions yield highly relevant information. 1) "What worried you most about your child's illness?" 2) "Why did that bother you?"

There are numerous recommendations for improvment of compliance. It is said that the providers first of all need to be made aware of the magnitude of the problem of noncompliance. There is a purported need to increase the patient's knowledge about his illness and treatment, to simplify the treatment regimen as much as possible, and to attend to the structure of the care provided so as to make return to and ultimate cooperation with the provider more attractive (1).

Throughout these reports in the literature there is the assumption that noncompliance is a significant problem that needs to be addressed. Rosenberg, (12) however, wonders whether noncompliance is a genuine problem in medical management or merely an affront to the providers. It may be a very real problem in long-term care of chronic illness or in prevention and much less a one in acute, episodic illness and acute problems for which a physician is consulted.

The widespread use of the term compliance and the highlighting of noncompliance as a problem of great magnitude does seem to belie a general view of the physician as an authority whose orders are not to go unheeded. This model may be more appropriate wherein there is a specific disease with a specific treatment, e.g. an infectious disease that is known to respond to an antibiotic that the physician needs to prescribe. However, in one survey almost half the mothers mentioned that problems other than physical illness or defect were their main concern with their child (7). Such problems ordinarily cannot be reduced as easily to clearly defined clinical entities that call for simply prescribed remedies. Where the vagueness of the clinical entity may preclude precise prescription, compliance may need to be weighed differently.

In any event, compliance implies an attitude and as such is not an either-or matter. To aim for it and the factors associated with it, e.g. patient satisfaction, can involve an elusive pursuit. The harder one tries, the more elusive it may become. Perhaps compliance is best viewed as a byproduct of a reasonable relationship between a physician and a patient in which both ultimately have a voice in the decisions that are made about treatment. To pursue compliance for its own sake may generate qimmickry and create a charade of an interaction. The ultimate aim ought not be compliance but successful resolution of the problem for which the physician is consulted. It well may be that noncompliance is detrimental in management of chronic illness or in prevention but therein it also is often evident that the involved psychological factors are not being addressed.

Consideration of some very practical matters in reference to compliance is in order. Above all, compliance can be expected only if the doctor and the patient are talking about treatment for the same condition. As Korsch and coworkers (10) note, the patient may have a "hidden agenda." Therefore, it is helpful for the physician to be curious about why a parent consults him at this moment. Such curiosity is especially important when the symptoms or behavior have been present for an extended period of time or when the severity of the symptoms and the concerns of the parent are markedly at variance. An example of the latter is seen in the office visit of a mother with her 18 month old child who had a respiratory illness. On the basis of her report and the physical examination there appeared to be no reason for her heightened concern. Further inquiry, however, revealed that several years

earlier this family had an 18 month old child die suddenly after very minor respiratory symptoms. When the physician empathically shared his understanding of her concern that her present child may share a similar fate, the mother sighed and talked further. She recalled how traumatic the earlier experience had been for them and how she found herself apprehensively waiting for this child to grow beyond 18 months. With her concern now obvious, it was relatively easier to help this mother tend her child more reasonably through this bout of illness that in fact proved to be minor.

It is wise for the physician to share diagnostic impressions with the parent and the nature of the difficulty as he perceives it since Korsch and coworkers (10) highlight how important it is for the physician to satisfy the mother's expectation that she will learn the cause and nature of her child's illness. When the problem is behavioral, the aim may be to describe the nature of the problem in terms of personal and interpersonal functioning. Ultimate compliance may rest on the physician's willingness to deal with questions and disagreements at this point for adherence to treatment plans is likely to rest at least in part on agreement with the diagnosis.

Out of an understandable urge to do something or to give something tangible the physician may quickly give advice for any of a variety of problems much as he might reach for his prescription pad. He may not recognize that definition of the problem alone is sufficient and such definition may be all that the parent needs. Not to have solutions often is more a matter of insufficient understanding of the problem.

At other times the parent does have a solution in mind but may feel uneasy about implementing it. The task herein is to sound out the parent and support his/her decision, offering at most suggestions about modifications. This latter approach not only makes the physician's task much easier but assures greater chances of success or in another sense, greater compliance.

The too ready dispensing of advice may betray a lack of trust in the capability of parents. To side with the child against the parent is certainly an occupational hazard against which pediatricians must guard. Such biases are reflected in lighthearted comments heard about a child's need for a "parentectomy." Casuso has observed that "if we could accept that nontraumatic parents are not of this earth, we could be more objective in enlisting their help when needed (5)."

The task is to be in tune with the family and help them devise solutions within their own family constellation. Too often there may be the danger of thinking in terms of absolutes - a way of doing something that is likely to coincide primarily with the biases of the physician. If there is attention to personality differences and an acceptance of assets and vulnerabilities in any particular style, the physician is more likely to help the patient capitalize on the former and avoid the impact of the latter. For example, where there is a tendency for "looseness" and vagueness, there is need to push for greater focus and greater structure. Where there is too much precision and decisiveness there needs to be a nudge toward a bit more freedom. Where there is heightened ambivalence so that decisions come only after painful agony if they come at all, the physician may place his weight on the side which

he senses the family reasonably leans though they are unable to see it or unable to make the obvious decision.

There is the danger that this discussion may make communication for compliance appear to be a time consuming venture that is not practical for the busy practitioner. For those concerned about the exigencies of time, two observations may dispel their fears. First there is Korsch's (10) observation that time does not appear to be a critical factor in the doctor-patient communication, as they found it to be satisfactory and effective in as little as five minutes.

Second, the above discussion is meant to develop a general framework within which the physician might approach the patient. It is assumed that in most encounters the interchange will naturally be brief and only in more complex situations will longer discourse be required. The important feature is that all interactions reflect the attitude of mutualality that is implied in the discussion.

The point is that of being on the alert for cues from the patient. These are the cues that come in the obvious but unexpressed manifestations of apprehension, the doubting attitude that is not openly expressed or the quizzical look. With these "resistances," as they are likely to be viewed, the task is to address and view them as obstacles to be removed through conscious awareness and review rather than as forces to be overpowered.

Communication as Treatment

History taking, discourse to learn about the nature of the symptoms, and specific treatment recommendations are generally accepted important ingredients of the doctor-patient interchange.

However, the same may not be true for communication as treatment in itself. Even if this aspect of communication is accepted as legitimate there is danger that physicians may concentrate on the verbal interchange without enough attention to the context in which the interchange occurs.

Communication is likely to effect treatment if the stage is set in the following two ways.

First the physician's warm, genuinely empathic approach needs to be the bedrock for the doctor-patient interchange. Barnlund (1) reports on observations of the preoperative and postoperative contacts between one physician and several patients undergoing surgery. He appeared to be genuinely interested in his patients, earnestly tried to provide the care they needed and attempted to be as clear and informative as possible. However, it also appeared clear "that he had one approach to all patients; that he failed to recognize differences in their reactions to stress; ..... that he made little effort to confer with them; that he did not adapt verbally, often using words that had no meaning for them; and that when he failed, he sought no explanation for his failure nor did he consider varying his behavior to adapt to this failure. Yet to unsophisticated observers, including some of his patients, he appared to be an adequate example of the doctor communicating with his patient."

There is danger that medical school courses on interviewing and behavioral sciences may cultivate such staged interactions with patients though the physician needs something more than a rehearsed, pat approach to patients. There is need to be attentive to what the patient presents and to meet him at his level. A warm

greeting may need to be coupled with open acceptance and invited expression of frustration and anger over having been made to wait, over having had to circle the medical center four times before finding a parking space or being forced by some "pushy" school nurse to have her child's rash examined when mother knows it amounts to nothing. There are the times when this acceptance of feelings requires the physician's frank apology for having inconvenienced the patient. At other times the physician would more appropriately help the patient recognize that the unexplained or overdetermined anger hides underlying fear or feelings of guilt.

Secondly, communication is likely to result in treatment when the focus is on the patient. This feature was illustrated very graphically in a study of mothers interacting with their newborn infants in the delivery room. (4) The investigators found the interactions between one particular physician and his patients to stand out. In these latter deliveries the focus was always on the mother and her baby, and the physician never allowed it to be directed toward himself. As a result he regularly created an atmosphere in which he interacted with the mother sensitively and gently, offering her much reassurance and support. It was her moment and he did all he could to make it a comfortable, meaningful experience.

All doctor-patient interchanges can be viewed in that light. Too often for the patient it may be too much like ascending the throne and leaving with a pontification. As has been said about psychotherapy, any doctor-patient interaction should be recognized primarily as an experience of which there may be a number of components.

Within the framework of this type of relationship there are a number of specific ways in which communication offers treatment. First, when the physician invites the patient to acknowledge a variety of feelings and offers approbation for doing so, there can be tremendous emotional relief through the mere expression of feelings. Secondly, in the verbalization of facts, fantasies, fears and wishes, there often emerges for the patient a sense of perspective that eludes him/her when left to mull over things in the privacy of his/her own inner world. Third the physician's gentle confrontations about observed behaviors which the patient may not otherwise acknowledge and his persistent demand for specifics in the face of generalizations and conclusions spontaneously lead to insights and further arrival at better perspective in a very natural, spontaneous manner.

Similar opportunities exist when a child is the patient. The child may change dramatically in an interchange when the physician is empathic and invites acknowledgement of feelings. A child may manifest an initial reticence and reluctance to share feelings because he is unsure of what response he may receive. Much too often the child has been raised in a world in which there is limited tolerance of feelings. More often than not he may be made to feel guilty about some feeling or other (3). With some anxiety and fear are totally unacceptable and anger is the primary way to deal with anxiety-provoking experiences. Others may call on a stiff upper lip to do the same. Regardless of type of feelings, there may be ready judgment of feelings as bad. Rather than reserve the judgment for the expression of feelings it is made freely on the experience of them, thereby putting him in the uncomfortable

and impossible position of needing to repress and avoid spontaneous stirrings as though one could turn these feelings off and on at random. After having had the experience of being able to acknowledge and share his feelings a child may settle down and be more responsive to the supportive overtures of family whereas previously there may have been a need on his part, because of anxiety or depression, to battle them in an attempt to keep a distance.

In another sense communication as treatment flows through the physician's role of educator as he imparts not only information but helps the patient develop personality skills by virtue of where he places premium. There are the opportunities to foster reflection and thereby help the patient assess more realistically his/her inner and outer world. The physician's acceptance of feelings without provoking guilt, and his demonstrated capacity to tolerate uncertainty may also be of help to the patient. Lastly, the physician may be able to help the patient appreciate how his illness may be a means of coping with troublesome feeling states such as anxiety or depression. (3) What evolves again from this discussion is that the physician try to have a patient's encounter with him to be a meaningful experience from which the patient, child and/or parent, can learn or further develop coping skills that can be carried forward into future stressful experiences. It is through such opportunity that each episode of illness, physical or emotional, becomes a truly growth inducing experience.

Speech Communication Training

The presence of courses in interviewing in the medical school curriculum attests to the importance with which medical educators view physician communication. Ordinarily, however, the emphasis is

on communication with adults with little if any attention to effective communication with children. Granted that there may be exceptions, too often the approach with children is that of an adult talking down to a child in a patronizing manner that does not invite dialogue at the child's level. At the risk of stereotypy, the fact is that such latter communication is rare or even non-existent in medical practice apart from that which occurs between a child and child psychiatrists or pediatricians trained in behavioral pediatrics. Much needs to be done to remedy that situation if interaction between physician and parent is to be truly expanded to include the child more meaningfully, especially in the more chronic disorders or where behavior problems prevail.

Be it the parent or the child, there are the following three areas that ought to be highligted in training for more effective communication.

1. The physician needs to explain to parent and child the nature of the child's illness, its causes and his treatment plan in a clear, direct, simplified, precise manner devoid of jargon which is generally accepted to be a deterrent to effective communication.

2. The physician needs to communicate in a manner that invites dialogue and not passively submissive compliance of either parent or child. Such communication is enhanced in three specific ways. First, it relies on open ended questions that allow for generation of hypotheses that are validated or rejected by more direct questions. Second, it requires attention to verbal and non-verbal cues that betray a "hidden agenda," i.e. non-expressed fears and worries, that need to be addressed. Third, an attitude

of simple curiosity about tangential matters that are volunteered or about general, summary statements wherein the bases for these have not been expressed.

3. An ability to confront, reflect back implicit but unexpressed feelings and attitudes without being critical. It is a skill that must be learned in a culture in which questions about attitudes and behavior ordinarily reflect criticism rather than a genuine interest in understanding. For the physician who is put in the role of counsellor, there needs to be a real shift toward a curious, "wishing to understand" attitude away from a judgmental, value oriented approach.

References

1. Barlund, D.C.: The mystification of meaning: Doctor-patient encounters. J. Med. Educ. 51: 716-725, 1976.
2. Becker, M.H.: Understanding patient compliance: The contributions of attitudes and other psychosocial factors. In Cohen, S.J. (Ed.), New Directions in Patient Compliance. Lexington Books, Lexington, Mass. 1979, pp 1-31.
3. Carek, D.J.: Focus on affect. Clin. Pediatrics. 17: 574-578, 1978.
4. Carek, D.J. and Capelli, A.J.: Mothers' reactions to their newborn infants. Presented at annual meeting of Amer. Acad. Child Psyciatry, Atlanta, Georgia, October, 1979.
5. Casuso, G.: Panel Report. The relationship between child analysis and the theory and practice of adult pychoanalysis. J. Amer. Psychoanal. Ass. 13: 159, 1965.
6. Collins, E.: Do we really advise the patient? J. Florida Med. Ass. 42: 111-115, 1955.
7. Deisher, R.W., Engel, W.L., Spielholz, R., and Standfast, S.J.: Mothers' opinions on their pediatric care. Pediatrics. 35: 82-90, 1965.
8. Dobbs, H.I. and Carek, D.J.: The conceptualization and teaching of medical interviewing. J. Med. Educ. 47: 272-276, 1972.
9. Francis, V., Korsch, B.M. and Morris, M.J.: Gaps in doctor-patient communication II. New Eng. J. Med. 280: 535-540, 1969.

10. Korsch, B.M., Gozzi, E.K., Francis, V.: Gaps in doctor-patient communication I. Pediatrics. 42: 855-871, 1968.

11. Moser, R.H.: The First five minutes. JAMA. 231: 1169-1170, 1975.

12. Rosenberg, S.G.: Patient education-an educator's view. In Sackett, D.L. and Haynes, R.B. (Ed.) Compliance with Therapeutic Regimens. John Hopkins U. Press. Baltimore, 1976, pp. 93-99.

13. Sandifer, M.G., Hordern, A., Green, L.M.: The psychiatric interview: The impact of the first three minutes. Amer. J. Psychiat. 126: 968-972, 1970.

14. Szasz, T.S. and Hollender, M.H.: The basic models of the doctor-patient relationship. Arch. Int. Med. 97:585-592, 1956.